FLORIDA DEPARTMENT OF JUVENILE JUSTICE
HEALTH STATUS CHECKLIST

Program: ____________________________
Provider: ____________________________
Youth Name: _________________________ JJIS#: _______________________

Date: __________________

A. SCREENER’S OBSERVATIONS:

1. Youth has obvious injury (Please indicate on body diagram)
   - Yes [ ] No [ ]
   If yes, describe ____________________________________________

2. Youth appears ill
   - Yes [ ] No [ ]
   If yes, describe ____________________________________________

3. Youth has difficulty moving
   - Yes [ ] No [ ]
   If yes, describe ____________________________________________

4. Youth has visible abrasions, cuts or bruises
   - Yes [ ] No [ ]
   If yes, describe ____________________________________________

B. YOUTH INTERVIEW:

CURRENT STATUS

1. Do you have any health complaints such as injuries, sickness or pain at the present time?
   - Yes [ ] No [ ]
   If yes, describe ____________________________________________

2. (For females) Are you pregnant or suspect that you might be pregnant?
   - Yes [ ] No [ ]

CHRONIC HEALTH PROBLEM
1. Do you have any of the following health problems?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
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<tr>
<td>Seizures</td>
<td></td>
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<tr>
<td>Heart Problems</td>
<td></td>
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<tr>
<td>Sickle Cell Disease</td>
<td></td>
<td></td>
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<tr>
<td>Cancer</td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis</td>
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</tr>
</tbody>
</table>

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Youth Name: ___________________________ JJIS#: __________________

MEDICATION
1. Are you taking any medication?
   If Yes, list (include over the counter medication) ____________

   Yes  No

2. Specifically, do you take any of the following:

   Insulin   Yes  No
   Seizure Medication
   Asthma Medication
   Heart Medication
   Birth Control Pills
   Tuberculosis Medication
   Antibiotics

C. MEDICAL ALERT REVIEW

   Youth has a medical alert   Yes  No

D. INTERVENTION AND DISPOSITION

   1. On-site minor first aid
   2. Emergency Transfer
   3. Designated Health Authority Notified
   4. On-site medical/nursing assessment
   5. No intervention needed
   6. Notification made that youth is receiving prescribed medication

Printed Name of Person Completing Checklist

Signature and Title of Person Completing Checklist  Date  Time

Referred to Licensed Health Care Provider: (Provide healthcare provider’s name and reason for referral)

__________________________________________________________

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